



Maine Medical Use Of Marijuana Program DESIGNATION FORM Patient Designates a Caregiver or a Dispensary

PATIENT INFORMATION

Last Name	First	M.I.	Date
Street Address			Apartment/Unit #
City	State	ZIP	
Phone	Expiration date of physician certification: _____		

CULTIVATION AUTHORIZATIONS

A. Are you growing or planning to possess any of your own flowering marijuana plants?

YES ☐ If, yes, how many _____
NO ☐

B. How many flowering plants do you want your designated caregiver or dispensary to grow? _____
The total of A and B must not exceed 6 plants.

CAREGIVER DESIGNATION

Last Name	First Name		
Street Address			Apartment/Unit #
City	State	ZIP	
Phone			
Caregiver MMMP Registration # assigned to this patient (if cultivating for the patient and required to register): _____			
If caregiver is not required to be registered, indicate: I live in same household with the caregiver _____ or The caregiver is a member of the family _____ Relationship _____			

DISPENSARY DESIGNATION

Name of Dispensary	
City	Phone
Name of Dispensary Representative:	
Name of caregiver, if any, who may pick up marijuana for me at the dispensary: _____	

MARIJUANA TRANSPORTATION (check all that apply)

I will pick up the marijuana from my caregiver/dispensary _____
The caregiver or dispensary will deliver my marijuana to me _____

PATIENT RIGHTS AND RESPONSIBILITIES

- My physician has certified that I have a condition that entitles me to participate in the Maine Medical Use of Marijuana Program until _____, when my physician certification expires. I have provided you with either a copy of that certification or a copy of my Maine Medical Use of Marijuana Program identification card as proof that I am authorized to participate in the program. I have also provided you a copy of my Maine issued driver license or other Maine issued photo identification card as proof of my identity. M
- If I am visiting from another state, I have provided you with a copy of the MMMP physician certification form completed by my physician in the state of _____ as evidence that I live in a state that authorizes marijuana for medical purposes and have a debilitating condition authorized under Maine law. I have also provided you with a copy of the driver license or other state issued photo identification card issued by that state as proof of my identity. I

In the event needed, ~~you are hereby authorized~~ to share this caregiver designation form and any copies of documents that I am required to provide to you with a member of the law enforcement community in order to verify the services you are providing to me are authorized under Maine law.

I have the right to terminate this agreement at any time upon written notice to you. This caregiver designation form is my property, and any authorized activity conveyed to you through this designation form ~~terminates upon my notice~~ to you. You must either dispose of the excess marijuana in your possession on my behalf, or replace me with another qualified patient. By rule of the Department of Health and Human Services, you will have 10 days from the date of notice to return this form to me at the address above.

In the event I terminate this agreement and you do not return this designation form to me, I authorize the Maine Department of Health and Human Services to demand the return of this designation form or take other action to enforce the Rules Governing the Maine Medical Use of Marijuana Program, which includes terminating the caregiver number that they assigned to you and that you have listed on this designation form.

Printed Name of Patient/Guardian: _____

Signed by Patient/Guardian: _____ Date: _____

Printed Name of Caregiver: _____

Signed by Caregiver: _____ Date: _____

Printed Name of Dispensary Representative: _____

Signed by Dispensary Representative, if any: _____ Date: _____

Expiration. This designation expires on (month/day/year) _____, or no later than 12 months after the date the I signed this designation form, whichever comes first.

RENEWAL OF DESIGNATION

In order to renew the designation of a caregiver or a dispensary, the patient must use a new designation form.